PATIENT MEDICAL HISTORY

Name: ____ **Date of birth:** ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❑Yes ❑No If yes, Specify:

____

Have you ever been hospitalized or had a major operation? ❑Yes ❑No If yes, Specify:

____

Have you ever had a serious head or neck injury? ❑Yes ❑No If yes, Specify:

____

Are you taking any medications, pills, or drugs? ❑Yes ❑No If yes, Specify:

____

____

____

Do you take, or have you taken, Phen-Fen or Redux? ❑Yes ❑No If yes, Specify:

____

Do you use tobacco? ❑Yes ❑No If yes, Specify:

____

Do you use controlled substances? ❑Yes ❑No If yes, Specify:

____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑Yes ❑No

Do You Snore? / Trouble Sleeping? / Tired During the Day? / Restless Leg Syndrome/ Use CPAP? ❑Yes ❑No

Women:	Are you Pregnant/Trying to get pregnant?	❑Yes ❑No
	Taking oral contraceptives?	❑Yes ❑No
	Nursing?	❑Yes ❑No

***Are you allergic to any of the following?**

❑Aspirin ❑Penicillin ❑Codeine ❑Local Anesthetics ❑Acrylic ❑Metal

❑Latex ❑Sulfa Drugs ❑Other If yes, explain: ______________________________

***Are you required to pre-medicate with antibiotics before dental treatment? ❑Yes ❑No**

If answer was yes for premed, please list reason why: ______________________________

PREFERRED PHARMACY:____

PATIENT MEDICAL HISTORY

Do you have, or have you had, any of the following:

Condition	Yes	No	Condition	Yes	No
Aids/HIV Positive	❑Yes	❑No	Hepatitis A	❑Yes	❑No
Alzheimer's Disease	❑Yes	❑No	Hepatitis B or C	❑Yes	❑No
Anaphylaxis	❑Yes	❑No	Herpes	❑Yes	❑No
Anemia	❑Yes	❑No	High Blood Pressure	❑Yes	❑No
Angina	❑Yes	❑No	High Cholesterol	❑Yes	❑No
Arthritis/Gout	❑Yes	❑No	Hives or Rash	❑Yes	❑No
Artificial Heart Valve	❑Yes	❑No	Hypoglycemia	❑Yes	❑No
Artificial Joint	❑Yes	❑No	Irregular Heartbeat	❑Yes	❑No
Asthma	❑Yes	❑No	Joint replacement or implant	❑Yes	❑No
Blood Disease	❑Yes	❑No	Kidney Problems	❑Yes	❑No
Blood Transfusion	❑Yes	❑No	Leukemia	❑Yes	❑No
Breathing Problem	❑Yes	❑No	Liver Disease	❑Yes	❑No
Bruise Easily	❑Yes	❑No	Low Blood Pressure	❑Yes	❑No
Cancer	❑Yes	❑No	Lung Disease	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No
Chest Pains	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Cortisone Medicine	❑Yes	❑No	Pain in Jaw Joints	❑Yes	❑No
Cold Sores/Fever Blisters	❑Yes	❑No	Parathyroid Disease	❑Yes	❑No
Congenital Heart Disorder	❑Yes	❑No	Psychiatric Care	❑Yes	❑No
Convulsions	❑Yes	❑No	Radiation Treatment	❑Yes	❑No
Diabetes	❑Yes	❑No	Recent Weight Loss	❑Yes	❑No
Drug Addiction	❑Yes	❑No	Renal Dialysis	❑Yes	❑No
Easily Winded	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No
Emphysema	❑Yes	❑No	Rheumatism	❑Yes	❑No
Epilepsy	❑Yes	❑No	Scarlet Fever	❑Yes	❑No
Excessive Bleeding	❑Yes	❑No	Seizures	❑Yes	❑No
Fainting Spells/Dizziness	❑Yes	❑No	Sinus Trouble	❑Yes	❑No
Frequent Cough	❑Yes	❑No	Spina Bifida	❑Yes	❑No
Frequent Diarrhea	❑Yes	❑No	Stomach/Intestinal Disease	❑Yes	❑No
Frequent Headaches	❑Yes	❑No	Stroke	❑Yes	❑No
Genital Herpes	❑Yes	❑No	Swelling of Limbs	❑Yes	❑No
Glaucoma	❑Yes	❑No	Thyroid Disease	❑Yes	❑No
Hay Fever	❑Yes	❑No	Tonsillitis	❑Yes	❑No
Heart Attack/Failure	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Heart Murmur	❑Yes	❑No	Tumors or Growths	❑Yes	❑No
Heart Pace Maker	❑Yes	❑No	Ulcers	❑Yes	❑No
Heart Trouble/Disease	❑Yes	❑No	Venereal Disease	❑Yes	❑No
Hemophilia	❑Yes	❑No			

Have you ever had any serious illness not listed above? ❑Yes ❑No

If yes, please explain:

____

____

- I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print Name___________________________________ **Signature** __________________________________

Date___________________ **❑Adult Patient ❑Parent or Guardian ❑Spouse**

Doctor Signature ____**Date**_________________

PATIENT INFORMATION (CONFIDENTIAL)

NAME ______ FIRST ______ MI ______ LAST ______ DATE ______

ADDRESS ______ CITY ______ STATE/ PROV. ______ ZIP/ P.C. ______

E-MAIL ______ CELL PHONE ______ HOME PHONE ______

SS#/SIN ______ BIRTHDATE ______

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL ______ CITY ______ STATE/ PROV. ______

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER ______ WORK PHONE ______

BUSINESS ADDRESS ______ CITY ______ STATE/ PROV. ______ ZIP/ P.C. ______

SPOUSE OR PARENT'S/GUARDIAN'S NAME ______ EMPLOYER ______ WORK PHONE ______

WHOM MAY WE THANK FOR REFERRING YOU? ______

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______ PHONE ______

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______ RELATIONSHIP TO PATIENT ______

ADDRESS ______ HOME PHONE ______

DRIVER'S LICENSE # ______ BIRTHDATE ______ SS#/SIN ______

EMPLOYER ______ WORK PHONE ______

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

BIRTHDATE ______ SS#/SIN ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ UNION OR LOCAL # ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE/ PROV. ______ ZIP/ P.C. ______

INSURANCE CO. ______ TEL. # ______ GRP # ______ POLICY / I.D. # ______

INS. CO. ADDRESS ______ CITY ______ STATE/ PROV. ______ ZIP/ P.C. ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX ANNUAL BENEFIT? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

BIRTHDATE ______ SS#/SIN ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ UNION OR LOCAL # ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE/ PROV. ______ ZIP/ P.C. ______

INSURANCE CO. ______ TEL. # ______ GRP # ______ POLICY / I.D. # ______

INS. CO. ADDRESS ______ CITY ______ STATE/ PROV. ______ ZIP/ P.C. ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX ANNUAL BENEFIT? ______

ITEM 07-0515767/27000

X ______

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR ______ PATIENT NUMBER

REGISTRATION